



## Compassionate Care Cover Letter

Please find attached the following documents that will be required to be completed by you and returned to our Patient Financial Counselor within the next 15 days. If you are unable to do so or need assistance then please contact the Patient Financial Counselor at 574-224-1446.

Each document requires your financial history as well as supporting documentation. If you would like to be considered for this program, please take the following steps and check off each step as it is completed.

- You must apply for Medical Assistance (Medicaid) and furnish evidence of denial.
- If you are unemployed and receiving unemployment benefits then please provide us with a copy of your unemployment letter or acceptance.
- Attach a complete copy of your Federal Tax Return and W2's.
- Attach a copy of 2 current complete bank statements on all bank accounts.
- Attach copies of 2 current pay stubs on all who work in household.
- If you're receiving Food Stamps then please provide a letter of approval for Food Stamps with the dollar amount from the Department of Family and Children.
- If you're receiving Child Support please provide a letter of proof and the dollar amount received.
- If you are living with someone and you're not working, we will need a letter from whoever is helping you with your financial needs.
- Complete all sections, sign and date the application.

Failure to return all documents will delay the process of your application.

Remember, if you have any questions or concerns or require assistance in completing your Compassionate Care forms then please contact:

Patient Financial Counselor at 574-224-1446

Between the hours of 8:00am and 4:30pm

1400 East 9<sup>th</sup> Rochester, Indiana 46975

Telephone: 574-224-1446

Facsimile: 574-224-1103

[www.woodlawnhospital.com](http://www.woodlawnhospital.com)

**Compassionate Care Application**

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Patient's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time

Spouse's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time

Marital Status: (circle one) *Single Married Widowed Divorced Legally Separated*

Dependents: (list each below)

1. \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_
2. \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_
3. \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_
4. \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

<b><u>Source of Income</u></b>	<b><u>Patient-Monthly:</u></b>	<b><u>Spouse-Monthly:</u></b>	<b><u>Total Monthly:</u></b>
Employment:	\$ _____	\$ _____	\$ _____
Social Security:	\$ _____	\$ _____	\$ _____
Unemployment:	\$ _____	\$ _____	\$ _____
Veterans Admin:	\$ _____	\$ _____	\$ _____
Child Support/Alimony:	\$ _____	\$ _____	\$ _____
Workman's Comp:	\$ _____	\$ _____	\$ _____
<b>Total Income:</b>	<b>\$ _____</b>	<b>\$ _____</b>	<b>\$ _____</b>

**Assets/Savings:**  
 (Patient and Spouse combined)

<u>Type</u>	<u>Location</u>	<u>Amount</u>
Checking:	_____	\$ _____
Savings:	_____	\$ _____
Rental Property:	_____	\$ _____
CD's:	_____	\$ _____
IRA's:	_____	\$ _____
Pension:	_____	\$ _____
Other:	_____	\$ _____

**Liabilities:**  
 (Bills and Debts combined)

<u>Type</u>	<u>Location</u>	<u>Amount</u>
Mortgage:	_____	\$ _____
CR Union:	_____	\$ _____
Banks:	_____	\$ _____
Credit Cards:	_____	\$ _____
Auto Loans:	_____	\$ _____
Student Loans:	_____	\$ _____
Other:	_____	\$ _____

**Assets/Property:**  
 Homestead: Location \_\_\_\_\_

Assessed Taxable Value: \$ \_\_\_\_\_ Mortgage Due: \_\_\_\_\_

Other Property: Location \_\_\_\_\_

Assessed Taxable Value: \$ \_\_\_\_\_ Mortgage Due: \_\_\_\_\_

Compassionate Care Application (continued)

**Assets/Auto or Truck:**

Make and Year: \_\_\_\_\_ Est. Value \$ \_\_\_\_\_ Loan Balance: \$ \_\_\_\_\_  
 Make and Year: \_\_\_\_\_ Est. Value \$ \_\_\_\_\_ Loan Balance: \$ \_\_\_\_\_

**Other Assets-Recreational Vehicles:**

<u>Type:</u>	<u>Estimated Value:</u>	<u>Loan Balance:</u>
Boat/Motor _____	\$ _____	\$ _____
Motorcycle _____	\$ _____	\$ _____
3-Wheeler/Quad _____	\$ _____	\$ _____
Motor Home _____	\$ _____	\$ _____
Snowmobile _____	\$ _____	\$ _____

**Regular Monthly Expenses:**

Rent \$ _____	Insurance Premiums \$ _____
Mortgage Payments \$ _____	Continuous Medication \$ _____
Utilities \$ _____	Other (specify) \$ _____
Auto Loan Pmts. \$ _____	Other (specify) \$ _____
Other Loan Pmts. \$ _____	

If you have not listed any income or earnings for the family, please explain how the family is supported. For example, how do you pay for your rent, for your groceries, etc?

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Do you now have a claim pending or plan to file a claim with an attorney for unemployment compensation, worker's compensation, or a third party liability? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Omitting information or providing fraudulent information will be a cause for permanent denial.

**PLEASE NOTE: Processing may be delayed if necessary verification is not provided.**

I hereby certify that all information is true to the best of my knowledge and give Woodlawn Hospital permission to verify the above information and check my credit through the credit bureau.

\_\_\_\_\_  
 Signature of Patient (or Responsible Party)

\_\_\_\_\_  
 Date